

## SECTION 8 BENEFITS AND LIMITATIONS

### Benefit Coverage

Effective for dates of service on or after September 1, 2005, certain optional Medicaid services were eliminated for individuals age 21 and over. Medicaid eligible individuals under the following categories of assistance now receive a limited benefit package through Medicaid:

<u>ME Code</u>	<u>Description</u>
01	Old Age Assistance
04	Permanently and Totally Disabled
05	Medical Assistance for Families – Adult
10	Vietnamese or Other Refugees
11	Medical Assistance – Old Age Assistance
13	Medical Assistance – Permanently and Totally Disabled
14	Supplemental Nursing Care – Old Age Assistance
16	Supplemental Nursing Care – Permanently and Totally Disabled
19	Cuban Refugee
21	Haitian Refugee
24	Russian Jew
26	Ethiopian Refugee
83	Presumptive Eligibility – Breast or Cervical Cancer Treatment
84	Regular Benefit – Breast or Cervical Cancer Treatment

*Individuals with the above medical eligibility (ME) codes who reside in a vendor nursing home do not receive a reduced benefit package. Claims submitted for items covered through the DME program for nursing home residents is the same as it was prior to September 1, 2005.*

The following DME items are not covered for adults receiving a reduced benefit package:

- apnea monitors
- artificial larynx and related items
- augmentative communication devices and accessories
- canes and crutches
- commodes, bed pans and urinals
- CPAP devices
- decubitus care equipment
- hospital beds and side rails
- humidifiers
- BiPAP machines
- IPPB machines
- nebulizers
- orthotics

- patient lifts and trapeze
- scooters
- suction pumps
- total parenteral nutrition (TPN), supplies and equipment
- walkers

The above items may be considered through the MO Medicaid Exceptions Unit on a case-by-case basis to determine if coverage meets the Exceptions Program criteria as set forth in 13 CSR 70-2.100. Providers may reference Section 20 of the MO Medicaid DME manual on the Internet at <http://www.dss.missouri.gov/dms/providers.htm> for exceptions information. The exception request form can be printed from this same site by accessing the “Medicaid Forms” link.

Continuous rental for CPAP or BiPAP S devices was eliminated November 1, 2005 for recipients continuing to receive a full comprehensive package. These devices are now reimbursed on a rent-to-purchase basis. Both purchase and rental reimbursement rates have been established as have allowed amounts and quantity limitations for supplies. Initial prior authorizations will be reviewed and approved for three (3) months. Prior authorization may be requested for an additional nine (9) months with documentation the recipient is compliant in using the device. If there is a discontinuation of usage of the CPAP or BiPAP S device at any time, providers are expected to stop billing for the equipment and related accessories and supplies.

Section 19.2 of the MO Medicaid DME manual includes covered HCPCS codes, modifiers, description of services, reimbursement guidelines, Medicaid allowed amounts and quantity limitations. This section also includes a “Reduced Benefit” column to show which items are covered (C) and non-covered (NC) for those individuals who now have a limited benefit package.

### **Services Provided in a Nursing Home**

DME is included in the nursing home per diem rate and not paid for separately with the exception of the following items:

- augmentative communication devices and accessories
- custom/power wheelchairs (when properly documented and approved)
- orthotic and prosthetic devices
- total parenteral nutrition (TPN)
- volume ventilators

### **DME Under a Home Health Plan Of Care**

Eligible MO Medicaid patients in a reduced benefit package may continue to receive non-covered DME while under a home health plan of care. The items must be included in the home health plan of care and must meet all other requirements of the DME program. The DME provider must have a copy of the home health plan of care signed by the physician in the patient’s file.

Claims for reimbursement of the DME item must include the certification “from” date that is on the home health plan of care. The home health certification “from” date must be entered on the claim form as follows based on the media through which the claim is filed:

HCFA 1500 claim form: field 10d

Emomed medical claim: HH cert date field

837 transaction: Populate data element LQ01 with UT;  
LQ02 with 485;  
FRM01 with 3; and  
FRM04 with the beginning certification date in eight digit  
CCYYMMDD format (20050701).

Claims will only be reimbursed when a Home Health program claim falls in the certification period indicated on the DME claim that has been processed. If a home health claim for the certification period has not been processed when the DME claim is received, the DME claim will cycle up to 45 days waiting for the system to process a home health claim. If a home health claim is not processed, the DME claim will deny.

### **Shoes for Diabetic Patients**

Diabetic shoes, inserts, additions and/or modifications continue to be considered for all MO Medicaid eligible patients only if the following criteria are met:

- 1) The patient has a diagnosis of 250.00 through 250.93, 648.80 and 648.83
- 2) The patient has one or more of the following conditions:
  - a. Previous amputation; or
  - b. History of previous foot ulceration of either foot; or
  - c. History of pre-ulcerative calluses of either foot; or
  - d. Peripheral neuropathy with evidence of callus formation of either foot; or
  - e. Foot deformity of either foot; or
  - f. Poor circulation in either foot; and
- 3) The physician who is managing the patient’s systemic diabetes condition has certified indications 1 and 2 are met and that he/she is treating the patient under a comprehensive plan of care for their diabetes and the patient needs diabetic shoes.

### **Orthopedic Shoes/Modifications**

Orthopedic shoes and modifications or additions to shoes are covered only in the following situations:

- The shoe(s) is an integral part of a brace. “Integral” means the shoe(s) is necessary for completing the brace. A pair of shoes may be reimbursed even if only one shoe is an integral part of a unilateral brace.

- The shoe(s) and/or modification is medically necessary for a patient under the age of 21.

**Modifiers**

All claims submitted to MO Medicaid for consideration of payment must be submitted with a modifier in addition to the HCPCS procedure code. Services covered in the DME program may be approved for purchase, rental, or repair. Section 19 of the MO Medicaid DME Manual documents coverage of services. The following modifiers are required for billing all services through the DME program:

NU = Purchase

RR = Rental

RP = Repair

Expanded HCY services also require the EP modifier. The requirement of the EP modifier is in addition to the modifier indicating purchase, rental or repair. **HCY services are restricted to patients under the age of 21.** Enteral products covered for the HCY population also require either a BA modifier, administered by a feeding tube, or BO modifier, if administered orally.

Use the following modifiers when billing oxygen for recipients who require more than 4 LPM:

- QF – greater than 4 LPM and portable oxygen is prescribed
- QG – greater than 4 LPM

**Calendar Month Billing**

Providers are to bill services through the end of the month for all Medicaid patients. Billing for the rental of equipment must state only one month for each line item, billing multiple line items for multiple months on the same claim is acceptable. Prior authorization requests for rental items should also be requested so the provider is able to bill calendar months. Providers should not overlap requested dates to avoid duplicate requests.

**Manual Pricing**

DME items, services or supplies, which do not have a MO Medicaid maximum allowed amount, are manually priced according to the following guidelines:

- HCY = cost + 20%
- Ostomy = cost + 20%
- Custom wheelchairs and accessories = 85% of the MSRP (Manufacturer's Suggested Retail Price)
- Power wheelchairs and accessories = 90% of the MSRP
- Augmentative communication devices and accessories = 85% of the MSRP
- Orthotics and Prosthetics = cost + 20%